



Patient Representative Amendment to the Patient Authorization Form

I hereby authorize the Pfizer Bridge Program to share my PHI, as that term is defined in the Pfizer Bridge Program "Patient Authorization Form" I previously signed (the Authorization), with the following additional individuals, on the same terms and conditions as stated in the Authorization:

Contact Name

Contact Phone/Fax

Contact Name

Contact Phone/Fax

Contact Name

Contact Phone/Fax

Print Patient's Name

Signature of Patient

Date

If the patient is a minor or is incapacitated and has a legal representative, obtain the following signature:

Signature of Personal Representative

Description of Authority

Date

P.O. Box 220746 • Charlotte, NC 28222-0746 • Phone: 1-800-645-1280 • Fax: 1-800-479-2562